



MRN:

CONSENT TO ASSESSMENT

NOTE: THIS FORM CANNOT BE COMPLETED ELECTRONICALLY. PLEASE PRINT AND SIGN BY HAND.

Patient's Name: (print) _____
 LAST FIRST

You have been referred for psychological assessment by yourself, physician, or third party insurer. If you have questions about any procedure or test being administered, you are free to ask for an explanation at any time. You may decline to take part in an assessment, procedure, intervention, or homework assignment at your discretion. You may decline to answer any question.

Description of Psychometric Testing:

Psychometric testing is a means of describing human strengths and weaknesses when material is presented in a standardized administration. For this reason, the test administration may seem rather formal and impersonal. Your results will be compared to those of the standardization sample. Standardization is the scientific means of helping researchers and clinicians measure specific qualities about you while minimizing any interference from other qualities. This allows for a clearer picture of your abilities and aids in understanding your specific qualities as compared to other people of similar backgrounds. The test(s) you will complete may help your doctor(s) to know how to better treat you as a unique individual.

Procedures:

Depending on the test(s) that you are asked to complete, you will be asked to perform a specific task. Tasks can range from solving word puzzles, drawing lines, looking at objects, answering direct questions, or even designing things with blocks. Depending on the test(s), your assessment may be as brief as 15 minutes or as long as several hours or days. Please understand for the sake of test security, Dr. Kovacs may not be able to give you much feedback on your performance until all the results are compiled. Some tests are copyrighted and kept under strict privacy. This means that you may not be able to review the specific test items or even your own answers at the completion of the testing without a court order.

Risks or Discomfort:

Many people find the testing procedures interesting and enjoyable. Depending on the test(s) administered, you may develop a mild headache. If this happens, it is quite normal. Psychological assessment involves testing your thinking and perception. By nature of the procedure, you may feel some boredom or fatigue.

Confidentiality:

There are legal and practical limits to confidentiality. For example, if your treatment is paid by a third party provider, they may have the right to request confidential material or require progress reports. A court may order disclosure of records. Administrative staff and the regulatory body of psychologists will have access to information on a need-to-know basis. On occasion, Dr. Kovacs may discuss your case with another psychologist colleague as part of routine practice. These individuals agree to keep material confidential, and any identifying information is withheld or disguised as much as possible. Records will be stored for seven years from the age of majority in a secured location as per requirements set under the Health Professionals Act.

Confidentiality will be legally breached if you or your child:

- Threatens to harm him/herself or is at-risk of incurring serious harm
- Threatens to harm others or engage in reckless behavior that is likely to put others in serious harm
- Disclose neglect, physical, emotional, or sexual abuse of a child, elder, or other vulnerable population
- Has been told not to drive but continues do so (adolescents only)
- Court order

What to Bring:

Any previous reports that you think might be helpful in understanding your child (e.g., relevant report cards, written homework samples, previous assessment or therapy reports, copies of learning plans, etc.). Also, please bring a snack for your child. If your child requires any supports such as hearing aids, glasses or medication, please ensure that he/she has these for the day(s) of the assessment.



STEPHANIE KOVACS, PH.D.
REGISTERED PSYCHOLOGIST
4794 JOYCE AVE. POWELL RIVER, BC V8A-3B6
TEL: (604) 414-7654 FAX: (604) 485-2820
WWW.SUNSHINEMENTALHEALTH.COM

File #:

Ensuring that your child has a good sleep the night before the appointment is important. Please ensure your child has also eaten a healthy breakfast on the day of testing.

You are welcome to wait in the waiting area for the duration of your child's testing appointment. Given the length of the appointment, however, it may be more comfortable for you to drop your child off at the start of the appointment and return at the end. It is not uncommon to finish testing prior to the scheduled time. When this happens, you will receive a courtesy call that your child is ready for pick-up.

Consent Statement:

I, _____, have been told and understand the limits of
PARENT / GUARDIAN NAME(S)

confidentiality, risks and benefits of assessment. This statement certifies the following: that I am the legal guardian of the named patient indicated below, that I consent to assessment for my child, and that all my questions have been answered. I give my informed consent for Dr. Kovacs to conduct a psychological assessment of my child

CHILD'S NAME

I understand and agree to all the information presented on page 1 and 2 of this consent document. I have been given the opportunity to ask questions and seek clarification on any information presented in this document.

Please note: *If the child has another parent/legal guardian who does not live with yourself and the child, and is not aware of the assessment (e.g., joint custody agreement), he/she must be made aware, and Dr. Kovacs must have written consent from him/her, before the assessment may begin. If this applies to your child, please inform Dr. Kovacs so that the appropriate parent/legal guardian may be contacted. Thank you.*

I have read/understand and accept the above noted terms and conditions.

Parent/Guardian Signature: _____ Date: ____/____/____
MM DD YYYY

2nd Parent/Guardian Signature: _____ Date: ____/____/____
(IF APPLICABLE) MM DD YYYY



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MRN: _____

FEE AND POLICY AGREEMENT FOR PROVISION OF PSYCHOLOGICAL SERVICES

Patient's Name: (print) _____
LAST FIRST

FEES

I, (please print) _____ agree to contract with Dr. Stephanie Kovacs of Sunshine Mental
FIRST LAST

Health for psychological services on a fee-for-service basis provided at an **hourly rate of \$185, consistent with current rates for Registered Psychologists. I understand and agree that the initial visit for assessment or therapy will be billed a one-time fee of \$200.**

Patients are responsible for payment of fees at each session or in accordance with the terms listed below. Dr. Kovacs will provide receipts after each session for third party reimbursement. All payment of accounts are ultimately the patient's responsibility.

POLICIES

- **24 hour cancellation policy.** First missed visit billed at half rate.
All subsequent missed or late-cancels will be billed at full rate. Your insurance may not cover this.
- **Sick** – Please do not come when sick. You will not be penalized. Phone or web sessions are available.
- **Checking In** – Always check in at front desk. Do not use text to announce your arrival.
- **Emergencies** – Dr. Kovacs is not an emergency-responder.
Appropriate Emergency Resources: 911, hospital, crisis hotline (24/7) 1-800-784-2433.
- **Communication** – Save therapy questions for therapy. Due to volume, Dr. Kovacs is unable to respond to every message but will always try. Missed calls without a voicemail will not be returned.
- **Outside the Office** – To protect your privacy, Dr. Kovacs will always follow your lead if we meet in the community. She will always pretend we have never met unless you decide otherwise. It's best not to discuss your therapy content if we meet in public.
- **Outstanding Payments** – Dr. Kovacs retains the right to charge 1.5% interest compounded monthly on balances outstanding beyond 90 days. By signing below, you understand that if the balance is based on a running account, 1.5% interest will be compounded monthly on the cumulative balance after the first 90 days of this signature. You further acknowledge and approve of Dr. Kovacs sending unpaid balances after 1 year of your last appointment to a collection service.
- **Letters/Forms Rates** – Billed by the hour. 15-30 mins (\$92.50)
- **Hardcopy Fees** – 50 cents / page if 25pgs or less. 25 cents / page if >25pgs.

I have read and understand the above fee agreement and policies for provision of psychological services. My signature below indicates that I understand this agreement and hereby agree to the terms and conditions stated herein.

SIGNATURE OF PATIENT / GUARDIAN

Date: ____ / ____ / ____
MM DD YYYY

Relationship to patient (if applicable): _____



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CHILD HISTORY

PLEASE PRINT

The information your provide is strictly confidential and will be used only to aid in your care. Exceptions to confidentiality discussed in your first visit also apply to the information on this form. If you feel uncomfortable answering any item, please leave it blank and discuss with Dr. Kovacs.

CHILD INFORMATION

FIRST NAME LAST NAME MI

DATE OF BIRTH: MONTH DAY YEAR AGE

GENDER: RACE/ETHNICITY BIRTHPLACE

PRIMARY ADDRESS

STREET ADDRESS CITY PROV POSTAL

EMERGENCY CONTACT:

FIRST NAME: _____ LAST NAME: _____
HOME PH: _____ CELL PH: _____ WORK PH: _____
RELATION TO PATIENT: _____

PARENT INFORMATION

PARENT #1

FIRST NAME LAST NAME AGE RELATION
HOME PH: ____ - ____ - ____ OK TO LEAVE VOICEMAIL? __Y __N
CELL PH: ____ - ____ - ____ OK TO LEAVE VOICEMAIL? __Y __N TEXT? __Y __N
WORK PH: ____ - ____ - ____ OK TO LEAVE VOICEMAIL? __Y __N
EMAIL ADDRESS: _____

EMPLOYMENT STATUS: FULL-TIME? PART-TIME? UNEMPLOYED? RETIRED?
CURRENT OCCUPATION: _____
COMPANY NAME: _____
#YEARS WITH COMPANY: _____
HIGHEST LEVEL OF EDUCATION: _____

PARENT #2

FIRST NAME	LAST NAME	AGE	RELATION
HOME PH: ____ - ____ - ____	OK TO LEAVE VOICEMAIL? __Y __N		
CELL PH: ____ - ____ - ____	OK TO LEAVE VOICEMAIL? __Y __N	TEXT? __Y __N	
WORK PH: ____ - ____ - ____	OK TO LEAVE VOICEMAIL? __Y __N		
EMAIL ADDRESS: _____			

EMPLOYMENT STATUS: FULL-TIME? PART-TIME? UNEMPLOYED? RETIRED?
CURRENT OCCUPATION: _____
COMPANY NAME: _____
#YEARS WITH COMPANY: _____
HIGHEST LEVEL OF EDUCATION: _____

FAMILY INFORMATION

PLEASE LIST ANY SIBLINGS, STEP-SIBLINGS, OR HALF-SIBLINGS; THEIR AGE; AND HOUSEHOLD.
Eg., Susan (sister, age 12, same home) Brian (step-brother, age 15, dad's home)

ACADEMIC INFORMATION

SCHOOL	GRADE	TEACHER
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DESCRIBE ANY SPECIAL PROGRAMS OR ACCOMMODATIONS YOUR CHILD UTILIZES AT SCHOOL
(EG, IEP, ONLINE CLASSES, HONORS, CMA, ETC.)

DESCRIBE HOW YOUR CHILD IS DOING ACADEMICALLY AND LIST ANY SPECIFIC AREAS OF CONCERN OR HIGH ACHIEVEMENT.

SOCIAL INFORMATION

RELIGION: _____
HOW IMPORTANT IS RELIGION/SPIRITUALITY IN YOUR HOUSEHOLD? _____

ANY CURRENT MARITAL STRESS IN THE HOME:

ANY CURRENT FINANCIAL STRESS:

IN GENERAL, HOW WOULD YOU DESCRIBE THE WAY YOUR CHILD GETS ALONG WITH PEOPLE?

HOW MANY CLOSE FRIENDS CAN YOUR CHILD RELY ON? _____

PLEASE DESCRIBE YOUR SOCIAL SUPPORT NETWORK:

DESCRIBE ANY PEER PROBLEMS:

IS YOUR CHILD SEXUALLY ACTIVE THAT YOU KNOW OF? ____ Y ____ N

LIST ANY REGULAR ACTIVITIES OR SPORT WITH WHICH YOUR CHILD IS INVOLVED:

MEDICAL HISTORY

DOCTOR'S NAME: _____

CURRENT PRESCRIPTIONS:

PAST PRESCRIPTIONS:

SIGNIFICANT HEALTH HISTORY OR CONDITIONS:

SUBSTANCE USE - IDENTIFY ANY USAGE YOU ARE AWARE OF FOR YOUR CHILD

CURRENT:

PAST:

LIST ANY EXPERIENCES WITH DRUG REHAB PROGRAMS OR CURRENT RECOVERY GROUPS:

LEGAL HISTORY

LIST ANY CRIMINAL CHARGES OR OPEN LEGAL DISPUTES:

LIFESTYLE

PLEASE DESCRIBE YOUR CHILD'S CURRENT LEVEL OF PHYSICAL ACTIVITY:

PLEASE DESCRIBE YOUR CHILD'S CURRENT DIET / EATING HABITS:

PLEASE DESCRIBE ANY PROBLEMS WITH YOUR CHILD'S SLEEP:

DEVELOPMENTAL HISTORY

DESCRIBE ANY SIGNIFICANT PROBLEMS DURING PREGNANCY:

CHECK ONE: VAGINAL DELIVERY C-SECTION

DESCRIBE ANY SIGNIFICANT PROBLEMS DURING DELIVERY:

CHILD'S WEIGHT AT BIRTH: _____

HOW WOULD YOU DESCRIBE YOUR CHILD'S GENERAL TEMPERAMENT IN INFANCY?

PLEASE IDENTIFY ANY DEVELOPMENTAL DELAYS REGARDING MILESTONES:

PHYSICAL (Eg., sitting, rolling, crawling, walking, toileting, etc.)

COGNITIVE & COMMUNICATION (Eg., speaking, counting, vocabulary, etc.)

SOCIAL & EMOTIONAL (Eg., empathy, making new friends, approaching others, integrating, right vs. wrong, etc.)

PSYCHOLOGICAL HISTORY

PREVIOUS COUNSELLING? (LIST NAMES, DATES, AND THE PRIMARY PROBLEMS):

EG., DR. SUSAN SMITH 2010-2012 DEPRESSION

PREVIOUS HOSPITALIZATIONS FOR PSYCHIATRIC PROBLEMS?

PREVIOUS TESTING / ASSESSMENTS?

FAMILY MENTAL HEALTH HISTORY (*EG, MOTHER (DEPRESSION)*)

MATERNAL SIDE _____

PATERNAL SIDE _____

HAS YOUR CHILD EVER DISCLOSED THOUGHTS OF SUICIDE OR HURTING HIM/HERSELF? DESCRIBE

DO YOU BELIEVE YOUR CHILD IS CURRENTLY SUICIDAL? IF SO, PLEASE EXPLAIN:

PLEASE DESCRIBE ANY SIGNIFICANT EVENTS THAT YOU BELIEVE HAVE AFFECTED YOUR CHILD:

HAS YOUR CHILD EVER EXPERIENCED A SERIOUS TRAUMA/ABUSE? IF SO, PLEASE EXPLAIN:

TELL ABOUT ANY PROBLEMS WITH DEPRESSION:

TELL ABOUT ANY PROBLEMS WITH ANXIETY:

TELL ABOUT ANY PROBLEMS WITH ANGER/AGGRESSION OR DEFIANCE:

HOW DO YOU EXPLAIN WHAT IS GOING ON IN YOUR LIFE?

WHAT ARE YOUR EXPECTATIONS FOR THERAPY OR ASSESSMENT? WHAT SPECIFIC GOALS WOULD YOU LIKE TO ADVANCE?

ANY OTHER IMPORTANT INFORMATION?

WHO REFERRED YOU TO SUNSHINE MENTAL HEALTH?
